SERFF Tracking Number:	*UFFL-127243529*	*State:*	*Arkansas*
Filing Company:	*United Home Life Insurance Company*	*State Tracking Number:*	*49322*
Company Tracking Number:	*200-679*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*200-679*		
Project Name/Number:	*/*		

Filing at a Glance

Company: United Home Life Insurance Company

Product Name: 200-679	SERFF Tr Num: UFFL-127243529	State: Arkansas
TOI: L08 Life - Other	SERFF Status: Closed-Approved-Closed	State Tr Num: 49322
Sub-TOI: L08.000 Life - Other	Co Tr Num: 200-679	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Linda Bird
	Author: Karen Hynes	Disposition Date: 08/09/2011
	Date Submitted: 07/18/2011	Disposition Status: Approved-Closed
Implementation Date Requested: 10/01/2011		Implementation Date:

State Filing Description:

General Information

Project Name:	Status of Filing in Domicile: Authorized
Project Number:	Date Approved in Domicile: 07/13/2011
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Individual Market Type:
Overall Rate Impact:	Filing Status Changed: 08/09/2011
	State Status Changed: 07/19/2011
Deemer Date:	Created By: Karen Hynes
Submitted By: Karen Hynes	Corresponding Filing Tracking Number:

Filing Description:

Attached please find the form referenced below for your review and approval. The requested implementation date of the form included in this submission is the later of your approval or October 1, 2011.

Form 200-679A 6-11 (AR) is an application for life insurance that will be used to apply for various products currently on file with your department and those that may be filed at a later date. The application replaces form 200-611A 1-10 (AR) previously approved by your department March 1, 2010.

The main differences between the enclosed application and that previously approved are we: a) changed the layout; b) changed the title; c) revised the underwriting questions; d) added a statement certifying to the accuracy of the tax identification number; e) added a HIPAA compliant authorization section; and f) revised the bank authorization.

SERFF Tracking Number:	*UFFL-127243529*	*State:*	*Arkansas*
Filing Company:	*United Home Life Insurance Company*	*State Tracking Number:*	*49322*
Company Tracking Number:	*200-679*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*200-679*		
Project Name/Number:	*/*		

We hereby certify we are in compliance with Ark. Code Ann. 23-79-138 and Regulation 49 and this submission meets the provisions of Rule 19.

We reserve the right to make any typographical corrections or make minor revisions to the appearance of the form due to printing constraints.

If you have any questions or need any additional information, please feel free to contact me via SERFF, at 317-692-7465 or by email at Karen.Hynes@infarmbureau.com.

Company and Contact

Filing Contact Information

Karen Hynes,
225 S East
Indianapolis, IN 46202

karen.hynes@infarmbureau.com
317-692-7465 [Phone]

Filing Company Information

United Home Life Insurance Company
225 S. East St.
Indianapolis, IN 46202
(317) 692-7465 ext. [Phone]

CoCode: 69922
Group Code:
Group Name:
FEIN Number: 35-0841899

State of Domicile: Indiana
Company Type: LAH
State ID Number:

Filing Fees

Fee Required?	Yes
Fee Amount:	$50.00
Retaliatory?	No
Fee Explanation:	AR imposes a filing fee of $50 per form.
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
United Home Life Insurance Company	$50.00	07/18/2011	49856641

SERFF Tracking Number:	*UFFL-127243529*	*State:*	*Arkansas*
Filing Company:	*United Home Life Insurance Company*	*State Tracking Number:*	*49322*
Company Tracking Number:	*200-679*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*200-679*		
Project Name/Number:	*/*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	08/09/2011	08/09/2011
Approved-Closed	Linda Bird	07/19/2011	07/19/2011

Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Form	Application for Life Insurance	Karen Hynes	08/04/2011	08/04/2011

Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Please Re-Open this Submission	Note To Filer	Linda Bird	08/03/2011	08/03/2011
Please Re-Open this Submission	Note To Reviewer	Karen Hynes	08/02/2011	08/02/2011

SERFF Tracking Number:	*UFFL-127243529*	*State:*	*Arkansas*
Filing Company:	*United Home Life Insurance Company*	*State Tracking Number:*	*49322*
Company Tracking Number:	*200-679*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*200-679*		
Project Name/Number:	*/*		

Disposition

Disposition Date: 08/09/2011
Implementation Date:
Status: Approved-Closed
Comment: Correction has been made to the original submission.

Rate data does NOT apply to filing.

SERFF Tracking Number:	*UFFL-127243529*	*State:*	*Arkansas*
Filing Company:	*United Home Life Insurance Company*	*State Tracking Number:*	*49322*
Company Tracking Number:	*200-679*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*200-679*		
Project Name/Number:	*/*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Form *(revised)*	Application for Life Insurance		Yes
Form	Application for Life Insurance	Replaced	Yes

SERFF Tracking Number:	*UFFL-127243529*	*State:*	*Arkansas*
Filing Company:	*United Home Life Insurance Company*	*State Tracking Number:*	*49322*
Company Tracking Number:	*200-679*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*200-679*		
Project Name/Number:	*/*		

Disposition

Disposition Date: 07/19/2011
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*UFFL-127243529*	*State:*	*Arkansas*
Filing Company:	*United Home Life Insurance Company*	*State Tracking Number:*	*49322*
Company Tracking Number:	*200-679*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*200-679*		
Project Name/Number:	*/*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Form *(revised)*	Application for Life Insurance		Yes
Form	Application for Life Insurance	Replaced	Yes

SERFF Tracking Number:	*UFFL-127243529*	*State:*	*Arkansas*
Filing Company:	*United Home Life Insurance Company*	*State Tracking Number:*	*49322*
Company Tracking Number:	*200-679*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*200-679*		
Project Name/Number:	*/*		

Amendment Letter

Submitted Date: 08/04/2011

Comments:

Thank you for re-opening this submission. The corrected application is included in the Form Schedule tab. In Section 4, we deleted "or 3" from the "Check here if you ...." language. No other changes have been made to the application.

At this time we are requesting your continued review and approval of this submission.

Please let me know if you have any questions or need any additional information.

Changed Items:

Form Schedule Item Changes:

Form Schedule Item Changes:

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
200-679A 6-11 (AR)	Application/Enrollment Form	Application for Life Insurance	Initial				50.000	200-679 - AR - 6-11.pdf

SERFF Tracking Number:	*UFFL-127243529*	*State:*	*Arkansas*
Filing Company:	*United Home Life Insurance Company*	*State Tracking Number:*	*49322*
Company Tracking Number:	*200-679*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*200-679*		
Project Name/Number:	*/*		

Note To Filer

Created By:

Linda Bird on 08/03/2011 08:32 AM

Last Edited By:

Linda Bird

Submitted On:

08/03/2011 08:32 AM

Subject:

Please Re-Open this Submission

Comments:

Filing has been re-opened in order for correction to be made.

SERFF Tracking Number:	*UFFL-127243529*	*State:*	*Arkansas*
Filing Company:	*United Home Life Insurance Company*	*State Tracking Number:*	*49322*
Company Tracking Number:	*200-679*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*200-679*		
Project Name/Number:	*/*		

Note To Reviewer

Created By:
Karen Hynes on 08/02/2011 12:41 PM
Last Edited By:
Karen Hynes
Submitted On:
08/02/2011 12:42 PM
Subject:
Please Re-Open this Submission
Comments:
Ms. Bird,

Please re-open this submission. I noticed an error in Section 4 of the application and would like to correct it. The application has not been used in Arkansas. I am waiting on a revised form from our graphics division and will forward it to you upon my receipt.

Thank you in advance for your cooperation.

Karen Hynes

SERFF Tracking Number:	*UFFL-127243529*	*State:*	*Arkansas*
Filing Company:	*United Home Life Insurance Company*	*State Tracking Number:*	*49322*
Company Tracking Number:	*200-679*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*200-679*		
Project Name/Number:	*/*		

Form Schedule

Lead Form Number: 200-679A 6-11 (AR)

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	200-679A 6-11 (AR)	Application/ Enrollment Form	Application for Life Insurance	Initial		50.000	200-679 - AR - 6-11.pdf

Application for Life Insurance

United Home Life Insurance Company • 225 S. East St. • P.O. Box 7192 • Indianapolis, IN 46207-7192 • 1-800-428-3001

SECTION 1 – Proposed Insured

Last Name	First Name	Middle Initial

Date of Birth (M-D-Y)	State of Birth	❑ Male ❑ Female

Marital Status	Height	Weight

Social Security Number	U.S. Citizen: ❑ Yes ❑ No *If no, give immigration status/type of visa:*

Street Address

City	State	Zip Code	Phone Number ( )

Employer/Occupation/Duties/How Long There **(Required)**

Billing Street Address	City	State	Zip Code

Secondary Addressee (For Past Due Notice)	Name	Street	City	State	Zip Code

SECTION 2 – Ownership (Complete only if Owner is other than Proposed Insured)

Owner Name	Relationship	Social Security Number

Owner Street Address	City	State	Zip Code

Contingent Owner Name	Relationship	Social Security Number

SECTION 3 – Beneficiary(ies)

Primary Beneficiary Name	Relationship	Age

Contingent Beneficiary Name	Relationship	Age

SECTION 4 – Plan of Insurance

Plan of Insurance ❑ Modified Death Benefit Whole Life
❑ Express Issue Deluxe ❑ Express Issue Premier

Face Amount: $_____

❑ Check here if you are willing to accept any product listed in this section for which you qualify based on this application. The insurance for which you qualify may have a graded death benefit in the first 2 years, a face amount less than any indicated on this application, and riders may not be available. All premiums will be applied toward the insurance for which you qualify.

If the Face Amount shown above is $10,000 or greater and the product issued is the Modified Death Benefit Whole Life, the following riders will be attached to the policy: Identity Theft Waiver of Premium Rider, Hospital Stay Waiver of Premium Rider and Common Carrier Accidental Death Benefit Rider.

❑ Accidental Death Benefit Rider (not available with Modified Death Benefit WL) $_____

SECTION 5 – Payment Information

Modal Premium: ❑ Annual ❑ Semi-Annual ❑ Qtrly. ❑ PAC* Modal Premium Amount $_____

$_____ paid with application.

***If selected, bank information on Page 5 must be fully completed.**

SECTION 6 – Other Insurance

Do you have any existing life insurance policies or annuity contracts? ❑ Yes ❑ No

If "Yes," please complete any necessary replacement forms.

SECTION 7 – Nicotine Use

Has the Proposed Insured used nicotine in any form in the past 12 months? ❑ Yes ❑ No

SECTION 8 – Physician Information

Name and Address of Family Physician **(Required)**	Family Physician Telephone Number **(Required)** ( ) -

SECTION 9 – Medical Questions

PART A – MODIFIED DEATH BENEFIT WHOLE LIFE – COMPLETE PART A ONLY

If any question in Part A is answered "Yes", you are not eligible for Modified Death Benefit Whole Life.

A. Do you currently receive kidney dialysis or require oxygen use or have you received or been told that you need an organ transplant or have you been diagnosed as having a terminal illness? (Terminal illness is defined as any illness diagnosed that would reasonably be expected to cause death within twenty-four (24) months.)	❑ Yes ❑ No
B. Do you require assistance to feed, bathe, dress or take your own medication or are you currently confined to a hospital, nursing home, mental facility, hospice, or require home health nursing care?	❑ Yes ❑ No
C. Have you ever tested positive for the AIDS virus or been diagnosed or treated, or recommended for treatment for AIDS (Acquired Immune Deficiency Syndrome), ARC (AIDS Related Complex) or any other immune disorder?	❑ Yes ❑ No
D. In the past twelve (12) months:	
1. Other than for temporary or minor conditions, have you been hospitalized two or more times?	❑ Yes ❑ No
2. Other than preventive, maintenance or risk lowering medications prescribed, have you been treated for or diagnosed with any cancer (other than Basal Cell skin cancer), heart attack, stroke, or had heart surgery (including angioplasty)?	❑ Yes ❑ No
3. Have you used any illegal drugs, been treated for or advised to have treatment for drug abuse?	❑ Yes ❑ No

PART B - EXPRESS ISSUE DELUXE – COMPLETE PARTS A & B ONLY

If any question in Part B is answered "Yes", you are not eligible for Express Issue Deluxe. Submit the case as Modified Death Benefit Whole Life.

A. In the past 2 years:	
1. Have you been diagnosed or treated for, or are you currently under treatment for:	
a. Alzheimer's Disease or Dementia?	❑ Yes ❑ No
b. Any form of Cancer (other than Basal Cell skin cancer) or Brain Tumor?	❑ Yes ❑ No
c. Other than preventive, maintenance or risk lowering medications prescribed, have you been diagnosed or treated for Heart or Circulatory Disorder (except controlled hypertension) or Stroke?	❑ Yes ❑ No
d. Had surgery for any Heart Disorder (including angioplasty) or Circulatory Disorder (except varicose veins)?	❑ Yes ❑ No
e. Sickle Cell Anemia or Kidney Disease (including dialysis) or Liver Disease (including hepatitis B & C)?	❑ Yes ❑ No
f. Lung Disease (except controlled, mild asthma not requiring any hospitalization in the past 2 years)?	❑ Yes ❑ No
g. ALS (Lou Gehrig's Disease) or Neurological disorders (except for controlled seizure disorder with no seizures in the past 2 years)?	❑ Yes ❑ No
2. Have you been advised by a medical professional to have any tests, surgery, treatment, or further medical evaluation that have not been performed or do you have any medical test results pending?	❑ Yes ❑ No
3. Have you excessively used, been treated for or been advised to have treatment for alcohol or drug abuse?	❑ Yes ❑ No
B. In the past 10 years have you been convicted of a felony or currently have pending charges for a felony; or currently on parole from a felony conviction?	❑ Yes ❑ No

PART C - EXPRESS ISSUE PREMIER – COMPLETE PARTS A, B, & C

If any question in Part C is answered "Yes", you are not eligible for Express Issue Premier. Submit the case as Express Issue Deluxe.

A. In the past 2 years:	
1. Have you been diagnosed or treated for, or are you currently under treatment for:	
a. Schizophrenia or Bipolar Disorder?	❑ Yes ❑ No
b. Diabetes requiring insulin treatment?	❑ Yes ❑ No
c. SLE (Systemic Lupus Erythematosus)?	❑ Yes ❑ No
2. Have you been convicted of operating a vehicle while intoxicated, or had your driver's license suspended or revoked?	❑ Yes ❑ No
3. Have you been declined or postponed for Life Insurance?	❑ Yes ❑ No
B. If under age 65, are you currently disabled, or been disabled in the last six months or at any time during the last six months received any disability compensation or been mentally or physically unable to complete 30 hours per week of active employment?	❑ Yes ❑ No
C. Do you now participate in, or do you have plans to participate in any hazardous sport or aviation?	❑ Yes ❑ No

SECTION 10 – Agreement/Acknowledgment

I hereby apply for the insurance indicated above and I am submitting the first premium. I have read (or have had read to me) all statements and answers recorded on this application, and I certify that the answers are true and accurate whether written by my own hand or not. I understand that my policy will not be effective until the date it is issued by the company and the premium paid.

I declare that I have read and received a copy of the Fair Credit Reporting Act/MIB, Inc., Notice.

WARNING

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

I, the Proposed Owner, and Proposed Insured (if other than Proposed Owner), hereby certify under penalties of perjury, that the tax identification number provided is true, correct and complete.

SECTION 11 – Authorization

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, or MIB, Inc., or other organization, institution, or person, that has any records or knowledge of me or my dependents, if they are to be insured, or our health, to give the United Home Life Insurance Company ("UHL") or its reinsurer(s) any such information. UHL may also disclose such information to reinsurers, the MIB, Inc., persons or entities performing business, professional or insurance functions for UHL or as may otherwise be legally allowed. I understand that I am giving permission to release medical information which may include treatment of physical and/or emotional illness, communicable diseases, alcohol or drug abuse treatment and/or HIV, AIDS, or AIDS-related information.

I understand that UHL may require that I submit to an HIV (HTL VIII) Screen; I authorize that test for underwriting purposes.

A photographic copy of this authorization shall be as valid as the original. This release may be used for any legitimate insurance purpose for up to two (2) years from the date of my signature below. I have a right to receive a copy of this authorization.

SECTION 12 – HIPAA Authorization

This authorization complies with the HIPAA Privacy Rule.

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy or pharmacy benefit manager, medical facility, or other health care provider that has provided payment, treatment or services to me or on my behalf within the past 10 years ("My Providers") to disclose my entire medical record, prescription history, medications prescribed and any other protected health information concerning me to United Home Life Insurance Company and its agents, employees, and representatives. United Home Life Insurance Company may disclose such information to reinsurers, the MIB, Inc., persons or entities performing business, professional or insurance functions for United Home Life Insurance Company or as may otherwise be legally allowed. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction.

This protected health information is to be disclosed under this authorization so that United Home Life Insurance Company may: 1) underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with United Home Life Insurance Company.

This authorization shall remain in force for 24 months following the date of my signature below, and a copy, image, or facsimile of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by providing written request for revocation to: United Home Life Insurance Company at P.O. Box 7192, Indianapolis IN 46207-7192, Attention: Director, Life Underwriting. I understand that a revocation is not effective to the extent that any of My Providers has already relied on this authorization to disclose information about me or to the extent that United Home Life Insurance Company has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization may be re-disclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

I understand that My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record, United Home Life Insurance Company may not be able to process my application, or if coverage has been issued may not be able to make any benefit payments. I have a right to receive a copy of this authorization.

SECTION 13 – Signatures

Signature applies to Sections 1 through 12. Review before signing.

Dated at _____ , this _____ day of _____ , _____
City State Month Year

_____
Signature of Proposed Insured or personal representative

_____
Description of personal representative's authority to act

_____
Signature of Owner (If other than Proposed Insured)

THE FOLLOWING SECTION MUST BE COMPLETED BY THE AGENT.

To the best of my knowledge and belief the applicant does ❑ does not ❑ have any existing life insurance policies or annuity contracts.

X _____ X _____

Printed Agent Name Agent's Signature

Agent Code _____ Agent's E-Mail_____

Agent: Phone # _____ Fax#_____ License Identification Number (_____)_____

State

AUTHORIZATION TO HONOR CHECKS
DRAWN BY THE UNITED HOME LIFE INSURANCE COMPANY, Indianapolis, Indiana

The initial modal premium must be quoted in Section 5 of the application.
We do not accept debit or credit cards.

Please select ONLY one option. Include a copy of voided check for bank draft.

□ Draft my account for the first premium (initial premium may be drafted immediately upon submission of this application). Please draft subsequent premiums on the _____ day of each month.

□ Draft my account for the first premium on: _____ . All subsequent drafts will occur on this same day each month.

□ Do NOT draft my account for the first premium. The initial premium is attached, is being mailed, or will be collected on delivery. **Please make check or money order payable to United Home Life Insurance Company.** Do not leave Payee blank or make it payable to the agent. Please draft subsequent premiums on the _____ day of each month.

The policy may be placed on direct quarterly mode temporarily if we do not receive complete bank information or if there is a difference in premium quoted.

I understand that my policy will not be effective until the policy is issued and premium paid.

Bank Name _____ Bank Address _____

As a convenience to me, I hereby request and authorize you to pay and charge to my account debit entries drawn on my account by and payable to the order of the United Home Life Insurance Company, Indianapolis, Indiana, provided there are sufficient collected funds in said account to pay the same upon presentation. I understand that I am personally liable for overdraft fees charged on said account if funds are not available at the designated date of withdrawal. I agree that your rights in respect to each such debit entry shall be the same as if it were a debit entry drawn on you and signed personally by me. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice, I agree that you shall be fully protected in honoring any such debit entry. I further agree that if any such debit entry be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance.

Account Number: _____ ☐ Checking ☐ Savings Routing Number: _____

Premium Payor's Printed Name: _____ Relationship to Insured: _____

Signature of Premium Payor: _____ Date: _____

In the event that a pre-printed void check or bank statement is not available, please complete the following information for account verification:

Financial Institution: _____ Phone Number: _____

Address: _____

I have personally verified that the above policy owner/payor has a current, active account.

Agent Name: _____ Agent #: _____

Agent Signature: _____ Date: _____

PLEASE DETACH AND GIVE TO APPLICANT

If you do not receive your Policy within 60 days from the date of your application, please write to UNITED HOME LIFE INSURANCE COMPANY, P.O. Box 7192, Indianapolis, Indiana 46207-7192

UNITED HOME LIFE INSURANCE COMPANY, Indianapolis, Indiana (Herein referred to as the Company)

All premium checks must be made payable to United Home Life Insurance Company. Do not make check payable to the agent or leave payee blank.

I understand that my policy will not be effective until the date it is issued by the company.

RECEIPT

Received from _____ The sum of $ _____

Being the 1st premium of _____ mode

Type of proposed insurance _____ Amount of proposed insurance $ _____

This receipt shall be void if given for check or draft which is not honored on presentation.

Dated at _____ on _____ , _____
Month Day Year

Agent Signature _____

FAIR CREDIT REPORTING ACT/MIB, INC., NOTICE

In compliance with the provisions of the FAIR CREDIT REPORTING ACT, this notice is to inform you that in connection with your application for insurance an investigative consumer report may be prepared. Such a report includes information as to the consumer's character, general reputation, personal characteristics, and mode of living and is obtained through personal interviews with friends, neighbors, and associates of the consumer. Upon written request, a complete and accurate disclosure of the nature and scope of the report, if one is made, will be provided.

Information regarding your insurability will be treated as confidential. United Home Life Insurance Company or its reinsurer(s) may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal FAIR CREDIT REPORTING ACT. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734, telephone number 866-692-6901 (TTY 866-346-3642 for hearing impaired).

United Home Life Insurance Company or its reinsurer(s) may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

IMPORTANT INFORMATION FOR VERIFYING IDENTIFICATION

To help fight the funding of terrorism and money-laundering activities, Federal law requires all financial institutions (including insurance companies) to obtain, verify and record information that identifies each person who engages in certain transactions. This means that when you apply for permanent life insurance or annuity products we will verify your name, residential address, date of birth, and other information that allows us to identify you. We may also ask to see your driver's license or passport.

SERFF Tracking Number:	*UFFL-127243529*	*State:*	*Arkansas*
Filing Company:	*United Home Life Insurance Company*	*State Tracking Number:*	*49322*
Company Tracking Number:	*200-679*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*200-679*		
Project Name/Number:	*/*		

Supporting Document Schedules

Item Status: **Status Date:**

Satisfied - Item: Flesch Certification
Comments:
Attachment:
Readability - Signed.pdf

Item Status: **Status Date:**

Bypassed - Item: Application
Bypass Reason: N/A - Submission does not include a policy.
Comments:

225 South East Street • P.O. Box 7192 • Indianapolis, IN 46207-7192

CERTIFICATION

I hereby certify the following score(s) on the Flesch Reading Ease Test.

Form 200-679A 6-11	50.0

Date: 6/15/2011

Joseph A. Martin
Chief Operating Officer
Senior Vice President, Life Operations
United Home Life Insurance Company

1-800-428-3001 • 1-317-692-7979 • FAX 1-317-692-7711 • www.unitedhomelife.com

SERFF Tracking Number:	*UFFL-127243529*	*State:*	*Arkansas*
Filing Company:	*United Home Life Insurance Company*	*State Tracking Number:*	*49322*
Company Tracking Number:	*200-679*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*200-679*		
Project Name/Number:	*/*		

Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date:	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
07/08/2011	Form	Application for Life Insurance	08/04/2011	200-679 - AR - 6-11.pdf (Superceded)

Application for Life Insurance

United Home Life Insurance Company • 225 S. East St. • P.O. Box 7192 • Indianapolis, IN 46207-7192 • 1-800-428-3001

SECTION 1 – Proposed Insured

Last Name	First Name	Middle Initial

Date of Birth (M-D-Y)	State of Birth	❑ Male ❑ Female

Marital Status	Height	Weight

Social Security Number	U.S. Citizen: ❑ Yes ❑ No *If no, give immigration status/type of visa:*

Street Address

City	State	Zip Code	Phone Number ( )

Employer/Occupation/Duties/How Long There (Required)

Billing Street Address	City	State	Zip Code

Secondary Addressee (For Past Due Notice)	Name	Street	City	State	Zip Code

SECTION 2 – Ownership (Complete only if Owner is other than Proposed Insured)

Owner Name	Relationship	Social Security Number	

Owner Street Address	City	State	Zip Code

Contingent Owner Name	Relationship	Social Security Number

SECTION 3 – Beneficiary(ies)

Primary Beneficiary Name	Relationship	Age

Contingent Beneficiary Name	Relationship	Age

SECTION 4 – Plan of Insurance

Plan of Insurance ❑ Modified Death Benefit Whole Life
❑ Express Issue Deluxe ❑ Express Issue Premier

Face Amount: $_____

❑ Check here if you are willing to accept any product listed in this section for which you qualify based on this application. The insurance for which you qualify may have a graded death benefit in the first 2 or 3 years, a face amount less than any indicated on this application, and riders may not be available. All premiums will be applied toward the insurance for which you qualify.

If the Face Amount shown above is $10,000 or greater and the product issued is the Modified Death Benefit Whole Life, the following riders will be attached to the policy: Identity Theft Waiver of Premium Rider, Hospital Stay Waiver of Premium Rider and Common Carrier Accidental Death Benefit Rider.

❑ Accidental Death Benefit Rider (not available with Modified Death Benefit WL) $_____

SECTION 5 – Payment Information

Modal Premium: ❑ Annual ❑ Semi-Annual ❑ Qtrly. ❑ PAC* Modal Premium Amount $_____

$_____ paid with application.

*If selected, bank information on Page 5 must be fully completed.

SECTION 6 – Other Insurance

Do you have any existing life insurance policies or annuity contracts? ❑ Yes ❑ No

If "Yes," please complete any necessary replacement forms.

SECTION 7 – Nicotine Use

Has the Proposed Insured used nicotine in any form in the past 12 months? ❑ Yes ❑ No

SECTION 8 – Physician Information

Name and Address of Family Physician (Required)	Family Physician Telephone Number (Required) ( ) -

SECTION 9 – Medical Questions

PART A – MODIFIED DEATH BENEFIT WHOLE LIFE – COMPLETE PART A ONLY

If any question in Part A is answered "Yes", you are not eligible for Modified Death Benefit Whole Life.

A. Do you currently receive kidney dialysis or require oxygen use or have you received or been told that you need an organ transplant or have you been diagnosed as having a terminal illness? (Terminal illness is defined as any illness diagnosed that would reasonably be expected to cause death within twenty-four (24) months.)	❑ Yes ❑ No
B. Do you require assistance to feed, bathe, dress or take your own medication or are you currently confined to a hospital, nursing home, mental facility, hospice, or require home health nursing care?	❑ Yes ❑ No
C. Have you ever tested positive for the AIDS virus or been diagnosed or treated, or recommended for treatment for AIDS (Acquired Immune Deficiency Syndrome), ARC (AIDS Related Complex) or any other immune disorder?	❑ Yes ❑ No
D. In the past twelve (12) months:	
1. Other than for temporary or minor conditions, have you been hospitalized two or more times?	❑ Yes ❑ No
2. Other than preventive, maintenance or risk lowering medications prescribed, have you been treated for or diagnosed with any cancer (other than Basal Cell skin cancer), heart attack, stroke, or had heart surgery (including angioplasty)?	❑ Yes ❑ No
3. Have you used any illegal drugs, been treated for or advised to have treatment for drug abuse?	❑ Yes ❑ No

PART B - EXPRESS ISSUE DELUXE – COMPLETE PARTS A & B ONLY

If any question in Part B is answered "Yes", you are not eligible for Express Issue Deluxe. Submit the case as Modified Death Benefit Whole Life.

A. In the past 2 years:	
1. Have you been diagnosed or treated for, or are you currently under treatment for:	
a. Alzheimer's Disease or Dementia?	❑ Yes ❑ No
b. Any form of Cancer (other than Basal Cell skin cancer) or Brain Tumor?	❑ Yes ❑ No
c. Other than preventive, maintenance or risk lowering medications prescribed, have you been diagnosed or treated for Heart or Circulatory Disorder (except controlled hypertension) or Stroke?	❑ Yes ❑ No
d. Had surgery for any Heart Disorder (including angioplasty) or Circulatory Disorder (except varicose veins)?	❑ Yes ❑ No
e. Sickle Cell Anemia or Kidney Disease (including dialysis) or Liver Disease (including hepatitis B & C)?	❑ Yes ❑ No
f. Lung Disease (except controlled, mild asthma not requiring any hospitalization in the past 2 years)?	❑ Yes ❑ No
g. ALS (Lou Gehrig's Disease) or Neurological disorders (except for controlled seizure disorder with no seizures in the past 2 years)?	❑ Yes ❑ No
2. Have you been advised by a medical professional to have any tests, surgery, treatment, or further medical evaluation that have not been performed or do you have any medical test results pending?	❑ Yes ❑ No
3. Have you excessively used, been treated for or been advised to have treatment for alcohol or drug abuse?	❑ Yes ❑ No
B. In the past 10 years have you been convicted of a felony or currently have pending charges for a felony; or currently on parole from a felony conviction?	❑ Yes ❑ No

PART C - EXPRESS ISSUE PREMIER – COMPLETE PARTS A, B, & C

If any question in Part C is answered "Yes", you are not eligible for Express Issue Premier. Submit the case as Express Issue Deluxe.

A. In the past 2 years:	
1. Have you been diagnosed or treated for, or are you currently under treatment for:	
a. Schizophrenia or Bipolar Disorder?	❑ Yes ❑ No
b. Diabetes requiring insulin treatment?	❑ Yes ❑ No
c. SLE (Systemic Lupus Erythematosus)?	❑ Yes ❑ No
2. Have you been convicted of operating a vehicle while intoxicated, or had your driver's license suspended or revoked?	❑ Yes ❑ No
3. Have you been declined or postponed for Life Insurance?	❑ Yes ❑ No
B. If under age 65, are you currently disabled, or been disabled in the last six months or at any time during the last six months received any disability compensation or been mentally or physically unable to complete 30 hours per week of active employment?	❑ Yes ❑ No
C. Do you now participate in, or do you have plans to participate in any hazardous sport or aviation?	❑ Yes ❑ No

SECTION 10 – Agreement/Acknowledgment

I hereby apply for the insurance indicated above and I am submitting the first premium. I have read (or have had read to me) all statements and answers recorded on this application, and I certify that the answers are true and accurate whether written by my own hand or not. I understand that my policy will not be effective until the date it is issued by the company and the premium paid.

I declare that I have read and received a copy of the Fair Credit Reporting Act/MIB, Inc., Notice.

WARNING

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

I, the Proposed Owner, and Proposed Insured (if other than Proposed Owner), hereby certify under penalties of perjury, that the tax identification number provided is true, correct and complete.

SECTION 11 – Authorization

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, or MIB, Inc., or other organization, institution, or person, that has any records or knowledge of me or my dependents, if they are to be insured, or our health, to give the United Home Life Insurance Company ("UHL") or its reinsurer(s) any such information. UHL may also disclose such information to reinsurers, the MIB, Inc., persons or entities performing business, professional or insurance functions for UHL or as may otherwise be legally allowed. I understand that I am giving permission to release medical information which may include treatment of physical and/or emotional illness, communicable diseases, alcohol or drug abuse treatment and/or HIV, AIDS, or AIDS-related information.

I understand that UHL may require that I submit to an HIV (HTL VIII) Screen; I authorize that test for underwriting purposes.

A photographic copy of this authorization shall be as valid as the original. This release may be used for any legitimate insurance purpose for up to two (2) years from the date of my signature below. I have a right to receive a copy of this authorization.

SECTION 12 – HIPAA Authorization

This authorization complies with the HIPAA Privacy Rule.

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy or pharmacy benefit manager, medical facility, or other health care provider that has provided payment, treatment or services to me or on my behalf within the past 10 years ("My Providers") to disclose my entire medical record, prescription history, medications prescribed and any other protected health information concerning me to United Home Life Insurance Company and its agents, employees, and representatives. United Home Life Insurance Company may disclose such information to reinsurers, the MIB, Inc., persons or entities performing business, professional or insurance functions for United Home Life Insurance Company or as may otherwise be legally allowed. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction.

This protected health information is to be disclosed under this authorization so that United Home Life Insurance Company may: 1) underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with United Home Life Insurance Company.

This authorization shall remain in force for 24 months following the date of my signature below, and a copy, image, or facsimile of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by providing written request for revocation to: United Home Life Insurance Company at P.O. Box 7192, Indianapolis IN 46207-7192, Attention: Director, Life Underwriting. I understand that a revocation is not effective to the extent that any of My Providers has already relied on this authorization to disclose information about me or to the extent that United Home Life Insurance Company has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization may be re-disclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

I understand that My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record, United Home Life Insurance Company may not be able to process my application, or if coverage has been issued may not be able to make any benefit payments. I have a right to receive a copy of this authorization.

SECTION 13 – Signatures

Signature applies to Sections 1 through 12. Review before signing.

Dated at _____ , this _____ day of _____ , _____
City State Month Year

_____
Signature of Proposed Insured or personal representative

_____
Description of personal representative's authority to act

_____
Signature of Owner (If other than Proposed Insured)

THE FOLLOWING SECTION MUST BE COMPLETED BY THE AGENT.

To the best of my knowledge and belief the applicant does ❑ does not ❑ have any existing life insurance policies or annuity contracts.

X _____ X _____

Printed Agent Name Agent's Signature

Agent Code _____ Agent's E-Mail_____

Agent: Phone # _____ Fax#_____ License Identification Number (_____)_____

State

AUTHORIZATION TO HONOR CHECKS
DRAWN BY THE UNITED HOME LIFE INSURANCE COMPANY, Indianapolis, Indiana

The initial modal premium must be quoted in Section 5 of the application.
We do not accept debit or credit cards.

Please select ONLY one option. Include a copy of voided check for bank draft.

□ Draft my account for the first premium (initial premium may be drafted immediately upon submission of this application). Please draft subsequent premiums on the _____ day of each month.

□ Draft my account for the first premium on: _____ . All subsequent drafts will occur on this same day each month.

□ Do NOT draft my account for the first premium. The initial premium is attached, is being mailed, or will be collected on delivery. **Please make check or money order payable to United Home Life Insurance Company.** Do not leave Payee blank or make it payable to the agent. Please draft subsequent premiums on the _____ day of each month.

The policy may be placed on direct quarterly mode temporarily if we do not receive complete bank information or if there is a difference in premium quoted.

I understand that my policy will not be effective until the policy is issued and premium paid.

Bank Name _____ Bank Address _____

As a convenience to me, I hereby request and authorize you to pay and charge to my account debit entries drawn on my account by and payable to the order of the United Home Life Insurance Company, Indianapolis, Indiana, provided there are sufficient collected funds in said account to pay the same upon presentation. I understand that I am personally liable for overdraft fees charged on said account if funds are not available at the designated date of withdrawal. I agree that your rights in respect to each such debit entry shall be the same as if it were a debit entry drawn on you and signed personally by me. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice, I agree that you shall be fully protected in honoring any such debit entry. I further agree that if any such debit entry be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance.

Account Number: _____ ☐ Checking ☐ Savings Routing Number: _____

Premium Payor's Printed Name: _____ Relationship to Insured: _____

Signature of Premium Payor: _____ Date: _____

In the event that a pre-printed void check or bank statement is not available, please complete the following information for account verification:

Financial Institution: _____ Phone Number: _____

Address: _____

I have personally verified that the above policy owner/payor has a current, active account.

Agent Name: _____ Agent #: _____

Agent Signature: _____ Date: _____

PLEASE DETACH AND GIVE TO APPLICANT

If you do not receive your Policy within 60 days from the date of your application, please write to UNITED HOME LIFE INSURANCE COMPANY, P.O. Box 7192, Indianapolis, Indiana 46207-7192

UNITED HOME LIFE INSURANCE COMPANY, Indianapolis, Indiana (Herein referred to as the Company)

All premium checks must be made payable to United Home Life Insurance Company. Do not make check payable to the agent or leave payee blank.

I understand that my policy will not be effective until the date it is issued by the company.

RECEIPT

Received from _____ The sum of $ _____

Being the 1st premium of _____ mode

Type of proposed insurance _____ Amount of proposed insurance $ _____

This receipt shall be void if given for check or draft which is not honored on presentation.

Dated at _____ on _____ , _____
Month Day Year

Agent Signature _____

FAIR CREDIT REPORTING ACT/MIB, INC., NOTICE

In compliance with the provisions of the FAIR CREDIT REPORTING ACT, this notice is to inform you that in connection with your application for insurance an investigative consumer report may be prepared. Such a report includes information as to the consumer's character, general reputation, personal characteristics, and mode of living and is obtained through personal interviews with friends, neighbors, and associates of the consumer. Upon written request, a complete and accurate disclosure of the nature and scope of the report, if one is made, will be provided.

Information regarding your insurability will be treated as confidential. United Home Life Insurance Company or its reinsurer(s) may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal FAIR CREDIT REPORTING ACT. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734, telephone number 866-692-6901 (TTY 866-346-3642 for hearing impaired).

United Home Life Insurance Company or its reinsurer(s) may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

IMPORTANT INFORMATION FOR VERIFYING IDENTIFICATION

To help fight the funding of terrorism and money-laundering activities, Federal law requires all financial institutions (including insurance companies) to obtain, verify and record information that identifies each person who engages in certain transactions. This means that when you apply for permanent life insurance or annuity products we will verify your name, residential address, date of birth, and other information that allows us to identify you. We may also ask to see your driver's license or passport.